

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 174

07050

7977

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
c. LENGTH OF STAY IN 1b <i>27y 10 1/2 mo</i>		d. STREET ADDRESS <i>1721 Belt Street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Harvey</i> Middle <i>Abrams</i> Last <i>Abrams</i>		4. DATE OF DEATH Month <i>July</i> Day <i>1</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March-21-1929</i>
9. AGE (In years last birthday) <i>27 yrs.</i>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min. <i>56</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George W. Abrams</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Hamilton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>1721 Belt Street</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>none</i> DUE TO (c) <i>none</i>		INTERVAL BETWEEN ONSET AND DEATH <i>months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>unspecified tumor in abdomen</i> <i>metastatic deposits in the pancreas</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July-1-</i> , 19 <i>56</i> , to <i>July-1-</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>June-30-</i> , 19 <i>56</i> , and that death occurred at <i>6:45</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i> M.D.		ADDRESS (Street, city or town, state) <i>Springfield State Hospital</i> DATE SIGNED <i>7/1/56</i>	
PHYSICIAN'S NAME (Type) <i>Walther H. Sonnenfeldt</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>7-5-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Eden Hill</i>		22d. LOCATION (City, town, or county) (State) <i>C. C. Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Home</i>		ADDRESS <i>130 E. London</i>	
24a. REC'D BY REGISTRAR <i>C. Harry Gier</i>		DATE <i>7-1-56</i>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1928		MOBILE		ALABAMA		U.S.A.		U.S.A.	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
MARRIED		1955		MOBILE		ALABAMA		U.S.A.		U.S.A.		JULY 6, 1968		MOBILE		ALABAMA	
OCCUPATION		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
CONDUCTOR		1968		MOBILE		ALABAMA		U.S.A.		U.S.A.		JULY 6, 1968		MOBILE		ALABAMA	
CAUSE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
HEART DISEASE		1968		MOBILE		ALABAMA		U.S.A.		U.S.A.		JULY 6, 1968		MOBILE		ALABAMA	
MANNER OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
NATURAL		1968		MOBILE		ALABAMA		U.S.A.		U.S.A.		JULY 6, 1968		MOBILE		ALABAMA	
CERTIFICATE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
JULY 6, 1968		1968		MOBILE		ALABAMA		U.S.A.		U.S.A.		JULY 6, 1968		MOBILE		ALABAMA	

RECEIVED
JUL 3 1968
BUREAU A. 2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 20a Film G201 8-3-56 ams

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll 7078 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 yrs. 8 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 2400 Hudson Street	
3. NAME OF DECEASED (Type or print) First Chester Middle AUGUSTYNOWICZ Last		4. DATE OF DEATH Month July Day 27 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 7/20/79 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Vincent Augustynowicz		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pericardial effusion (c) Pulmonary edema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old contusion rt. side of brain, Prostatic abscess Psychosis with arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH neither 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Choked by another patient			
20c. TIME OF INJURY Month, Day, Year 7/25 1956		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield Hospital		20f. (City or town) (County) (State) Sykesville, Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James T. Marsh		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-31-56	
22c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM		22d. LOCATION (City, town, or county) (State) GERMAN HILL Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Seiler		24a. REC'D BY REGISTRAR 7/31/56	
ADDRESS 901 S. CONKLING ST BALTO., MD		24b. REGISTRAR'S SIGNATURE C. Harry Sears	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Previous Illnesses		Injury or Poison	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	
Date of Examination		Time of Examination		Place of Examination		City or Town	
County		State		District		Precinct	
Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Witness	
Date of Registration		Time of Registration		Place of Registration		City or Town	
County		State		District		Precinct	

BUREAU V. S.

JUL 31 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07052

Item 1c, Film G200, 7/17/56 bh CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 3 months, 14 days		d. STREET ADDRESS 3022 Roselawn Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Sarah Elizabeth Baker Baker		4. DATE OF DEATH Month 7 Day 7 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-72
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Wooden		14. MOTHER'S MAIDEN NAME Wilhelmina	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT nephew		Address Hospital Records & Mr. Vernon Barlag 3022 Roselawn	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia & 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome assoc. with senile brain disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 23, 1956 , to July 7, 1956 , that I last saw the deceased alive on July 7, 1956 , and that death occurred 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edmund Lusthaus Springfield State Hospital July 7, 1956 M.D. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) EDMUND LUSTHAUS Sykesville, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/1956	
22c. NAME OF CEMETERY OR CREMATORY Loudon Pk National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road #14	
24a. REC'D BY REGISTRAR DATE 7-7-56		24b. REGISTRAR'S SIGNATURE C. Henry	

MASSACHUSETTS DEPARTMENT OF HEALTH-BALDWIN 18

JUL 10 1955

RECEIVED

7080

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE L. BARTHOLOMEW</u>				4. DATE OF DEATH Month Day Year <u>July 31 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1872</u> <u>2-11-1872</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Bartholomew</u>				14. MOTHER'S MAIDEN NAME <u>Alice Jordan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Annie M. Bartholomew - Sykesville, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension, chronic myocarditis</u> DUE TO (c) <u>senile changes</u>						INTERVAL BETWEEN ONSET OF DEATH <u>20 yrs</u> <u>30 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1935</u> , 19 <u> </u> , to <u>31 August 1956</u> , that I last saw the deceased alive on <u>30 August 1956</u> , and that death occurred at <u>4:00 A.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Liberty Road at Eldersburg</u> <u>8.1.56</u>							
ACTUAL SIGNATURE <u>[Signature]</u>				PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u> <u>Sykesville P.O., Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-3-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur H. Haight Sykesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8-1-56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V.

AUG 5 1956

RECEIVED
AUG 5 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b 5 mos.		d. STREET ADDRESS 5810 Johnson Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Bertha Klug Baxter		4. DATE OF DEATH Month July Day 3 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1870
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR: Months 3 Days 19 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Klug		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Springfield Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyonephrosis DUE TO (c) Decubitus ulcer		INTERVAL BETWEEN ONSET AND DEATH 1 week Unknown Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with senile brain dis., with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 6, 1956 , to July 3, 1956 , that I last saw the deceased alive on July 2, 1956 , and that death occurred at 2:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7-3-56	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. (BURIAL) CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-6-56	
22c. NAME OF CEMETERY OR CREMATORY FR. LINCOLN		22d. LOCATION (City, town, or county) (State) PR. GEO. CO. MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc. 317 Pa. Ave. S.E.		24a. REC'D BY REGISTRAR 5 1956	
24b. REGISTRAR'S SIGNATURE C. Larry Hays			

BUREAU V. S.

JUL 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

76

7982

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION MILLS</u>				c. LENGTH OF STAY IN 1b <u>1 WEEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEADOW VIEW CONV. HOME</u>				d. STREET ADDRESS <u>54 E. MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>ANNE</u> Last <u>BEMILLER</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 31, 1878</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>WORCESTER, CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN J. CONNER</u>				14. MOTHER'S MAIDEN NAME <u>MARYJANE MUMFORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>MISS ELIZABETH BEMILLER</u>				Address <u>WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June 28, 1956</u> , to <u>July 13, 1956</u> , that I last saw the deceased alive on <u>July 13, 1956</u> , and that death occurred at <u>7:05 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Julius Chepko</u>				ADDRESS (Street, city or town, state) <u>Westminster Md</u>			
PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>				DATE SIGNED <u>7/16/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 16, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL WESTMINSTER MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer Jr.</u>				ADDRESS <u>Westminster Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 7-16-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1956 17 JUL

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07056

Reg. Dist. No.

7083

1. PLACE OF DEATH a. COUNTY Carrol MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lerrance First Joseph Middle Boyle Last Boyle				4. DATE OF DEATH July Month 15 Day 19 Year 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-20-1889	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) county investigator		10b. KIND OF BUSINESS OR INDUSTRY unk		9. AGE (In years last birthday) 67 yrs.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Peter J. Boyle				12. CITIZEN OF WHAT COUNTRY? U.S.A			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service) Unknown				14. MOTHER'S MAIDEN NAME Mary Toner			
16. SOCIAL SECURITY NO. unk				17. INFORMANT Records of Springfield State Hospital Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic bronchopneumonia Uremia DUE TO (b) Hypertension (c) Involuntional Melancholia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 7 days 5 years 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8th 19 56 to July 15 19 56 that I last saw the deceased alive on 7-11-1956 , 19 56 , and that death occurred at 8 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield St. Hospital DATE SIGNED 7/15/56			
PHYSICIAN'S NAME (Type) Edmund LUSTHAUS Sykesville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-18-56		22c. NAME OF CEMETERY OR CREMATORY ST. PETER & PAUL CEM.		22d. LOCATION (City, town, or county) (State) CUMBERLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Rugg ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE 7-15-56		24b. REGISTRAR'S SIGNATURE C. Tracy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. EDUCATION</p>		<p>9. RELIGION</p>		<p>10. RACE</p>	
<p>11. CAUSE OF DEATH</p>		<p>12. MANNER OF DEATH</p>		<p>13. PLACE OF DEATH</p>		<p>14. DATE OF DEATH</p>		<p>15. TIME OF DEATH</p>	
<p>16. SIGNATURE OF PHYSICIAN</p>		<p>17. SIGNATURE OF CORONER</p>		<p>18. SIGNATURE OF WITNESSES</p>		<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF NEXT OF KIN</p>	

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 BUREAU VI

7084

CERTIFICATE OF DEATH

08138

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegheny</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>16 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>		d. STREET ADDRESS <i>Not Known</i>	
3. NAME OF DECEASED (Type or print) <i>Eliza Jeannette</i> First Middle Last <i>CLEMENTS</i>		4. DATE OF DEATH Month <i>July</i> Day <i>31</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 16, 1871?</i>
9. AGE (In years last birthday) <i>84?</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Not Known</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William Horner</i>		14. MOTHER'S MAIDEN NAME <i>Jane Horner?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hospital records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident with</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>pulmonary edema</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Simple Psychosis - Simple deterioration of 16 years + standing</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 30</i> , 19 <i>56</i> , to <i>July 31</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>July 31</i> , 19 <i>56</i> , and that death occurred at <i>8:45 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Gertrud Sormenfeldt</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>Springfield State Hospital July 31, 1956</i>	
PHYSICIAN'S NAME (Type) <i>Gertrud Sormenfeldt M.D.</i>		<i>Sykesville, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8-3-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Greenmount</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. O. Mitchell</i>		ADDRESS <i>1900 Eutaw Place</i>	
24a. REC'D BY REGISTRAR DATE <i>8/2/56</i>		24b. REGISTRAR'S SIGNATURE <i>C. Harry Baker</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
DATE		TIME	

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AUG 9 1956
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07057

Item 18 Film G201 8-17-56 ams

CERTIFICATE OF DEATH

Reg. Dist. No. 174

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b since 3-31-53			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Tyler COLLINS				4. DATE OF DEATH Month Day Year 7 29 19 56			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-79		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY carpentry		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Daniel Collins				14. MOTHER'S MAIDEN NAME Sarah Ann Houser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) unk		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diagnosis not completed, suspected malignancy 164X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant neoplasm of thoracic organs, unspecified DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from oct 20, 19 54 , to July 29, 19 56 , that I last saw the deceased alive on July 28, 1956 , and that death occurred at 8:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edmund Lusthaus M.D. Springfield State Hospital 7-29-56							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) Sykesville, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8-1-56		Rock Creek		Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey - Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 7-30-56		24b. REGISTRAR'S SIGNATURE C. Harry Wier	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

RECEIVED
AUG 2 1956
BUREAU V. 3

NAME OF DECEASED [Faint text, possibly "JOHN J. ..."]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "35"]	
DATE OF BIRTH [Faint text, possibly "12-1-21"]		PLACE OF BIRTH [Faint text, possibly "BALTIMORE, MD"]		OCCUPATION [Faint text, possibly "LABORER"]	
DATE OF DEATH [Faint text, possibly "8-1-56"]		PLACE OF DEATH [Faint text, possibly "HOME"]		CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		MANNER OF DEATH [Faint text, possibly "NATURAL"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "J. J. ..."]	
SIGNATURE OF REGISTRAR [Faint text, possibly "J. J. ..."]		SIGNATURE OF WITNESS [Faint text, possibly "J. J. ..."]		SIGNATURE OF DECEASED [Faint text, possibly "J. J. ..."]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67058

Reg. Dist. No. 74

7986

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Watersville</u>			c. LENGTH OF STAY IN 1b <u>unk</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Watersville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Roy</u> First				Middle <u>Duvall</u> Last		4. DATE OF DEATH <u>July 12 1956</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1899</u>		9. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Otha Duvall</u>					14. MOTHER'S MAIDEN NAME <u>Emma Hobbs</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Vernon Duvall, Woodbine, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY DISEASE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input "="" checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> 									
ACTUAL SIGNATURE <u>James T. Marsh</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>James T. Marsh M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>7/12/54</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>7-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jennings Chapel</u>			22d. LOCATION (City, town, or county) (State) <u>Florence, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u> ADDRESS						24a. REC'D BY REGISTRAR <u>7-15-56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MINNESOTA STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for narrative notes.

BUREAU V. 81

UL 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

67059

7987

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Manchester</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. #1, Manchester</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Clifford</u>	(Middle) <u>Wayne</u>	(Last) <u>Ford</u>
4. DATE OF DEATH	(Month) <u>July</u>	(Day) <u>2,</u>	(Year) <u>1956</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE <u>MARRIED</u> WIDOWER <u>WIDOW</u> (Specify)	8. DATE OF BIRTH <u>4/24/92</u>
9. AGE last birthday <u>64</u> yrs.		10. If under 1 year (If under 24 hrs. Months Days Hours Min.) <u>3</u> <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive-(last 11 yrs. Farmer)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Tiffin, Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ford</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Evans</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>212-07-6345</u>	
17. INFORMANT AND ADDRESS <u>Frances R. Ford, R.D. #1, Manchester, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐22. I hereby certify that I attended the deceased from 2/8, 1954, to July 2, 1956, that I last saw the deceasedalive on 6/26, 1956, and that death occurred at 10 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W.H. HoardM.D. Manchester, Md7/2/5623. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

JUL 4 - 1956W.H. HoardDaved R. Martin, Manchester, Md

RECEIVED
JUL 11 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07060

Reg. Dist. No. 77

7988

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenmount</u> c. LENGTH OF STAY IN 1b <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>✓</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenmount</u> d. STREET ADDRESS <u>✓</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>SADIE</u> Middle <u>HARRIS</u> Last <u>FREDERICK</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1956</u>													
5. SEX <u>♀</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 7-1900</u>		9. AGE (In years last birthday) <u>55</u> yrs. <table border="1" style="display: inline-table; width: 100%;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>									
13. FATHER'S NAME <u>Benjamin Harris</u>				14. MOTHER'S MAIDEN NAME <u>Mary I Alban</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>213-18-8296</u>		17. INFORMANT Address <u>J A Frederick - Greenmount Md</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hanging</u> DUE TO (b) <u>974X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>974X</u> DUE TO (c) <u>974X</u>								INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>She hanged self -</u>													
20c. TIME OF INJURY <u>7-5</u> p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Greenmount</u>		(County) <u>Carroll</u>		(State) <u>md</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>James I Tharsh</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>7/5/56</u>								
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 8/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Snoddersburg</u>				22d. LOCATION (City, town, or county) <u>Carroll co</u>		(State) <u>md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C. Tipton, Hainpstead Md</u>						ADDRESS		24a. REC'D BY REGISTRAR <u>DATE 7/6/56</u>		24b. REGISTRAR'S SIGNATURE <u>Henry J. Reed</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND—Baltimore
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
 JUL 10 1956
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07061

7089

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 10mos.; 16days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3213 Westfield Ave.			
3. NAME OF DECEASED (Type or print) First William Middle Singleton Last GEOGHEGAN				4. DATE OF DEATH Month July Day 17 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 4, 1900	
				9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical work				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Benjamin Geoghegan				14. MOTHER'S MAIDEN NAME Vendie McNamara			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give year or dates of service) W.W.I.				16. SOCIAL SECURITY NO. 220-09-6435		17. INFORMANT Springfield Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric hemorrhage 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Duodenal ulcer DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Hours Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with intoxication, alcohol intox., with psychotic reaction Alcoholic cirrhosis.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 1 , 1955, to July 17 , 1956, that I last saw the deceased alive on July 17 , 1956, and that death occurred at 10:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/17/56							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				City Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.				ADDRESS 6009 Hayfield Rd		24a. REC'D BY REGISTRAR DATE 7/17/56	
				24b. REGISTRAR'S SIGNATURE C. H. H. H.			

CERTIFICATE OF DEATH

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

NAME OF PHYSICIAN

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

BUREAU V. S.

JUL 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07062
Items 9,18 Film G200 7-16-56 et
7090
CERTIFICATE OF DEATH

Reg. Dist. No.

16

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Finksburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rockdale, Baltimore 7			
c. LENGTH OF STAY IN 1b 5 days				d. STREET ADDRESS 3539 Milford Mill, Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Finksburg Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Samuel Middle George Last Harden				4. DATE OF DEATH Month July Day 3 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 20, 1884	
9. AGE (In years last birthday) 72 7/8 yrs.		IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 7 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (State or foreign country) Cleveland, Tenn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard Harden				14. MOTHER'S MAIDEN NAME Mary Chatman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-07-9176			
17. INFORMANT Mrs. Marie C. Hendricks, Reisterstown, Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aplastic Anemia 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Aug 15, 1955 , to July 3, 1956 , that I last saw the deceased alive on June 28, 1956 , and that death occurred at 6:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pikesville 8, Md. DATE SIGNED July 3, 1956							
ACTUAL SIGNATURE Waverly S. Green, Jr. M.D.				PHYSICIAN'S NAME (Type) Waverly S. Green			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1956		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell				24a. REC'D BY REGISTRAR Harriet Muller		24b. REGISTRAR'S SIGNATURE Harriet Muller	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07063

Reg. Dist. No.

7091

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b since 6-29-55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS —			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle Herbert Last HARDING				4. DATE OF DEATH Month July Day 9th Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 11, 1878	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) near Sykesville, Md.	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Robert A. Harding				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records of Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis with hypertension DUE TO (c) more than 15 years				INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis, about 4 yrs				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —		20c. TIME OF INJURY Month, Day, Year Hour a. m. ———— 19 p. m. ————		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —		(State) —	
21. I certify that I attended the deceased from Aug. 22 , 19 55 , to July 9 , 19 56 , that I last saw the deceased alive on July 9 , 19 56 , and that death occurred at 9:45A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin Gross M.D.				ADDRESS (Street, city or town, state) Sykesville, Maryland		DATE SIGNED 7/9/56	
PHYSICIAN'S NAME (Type) Martin Gross, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 7-12-56		22c. NAME OF CEMETERY OR CREMATORY Springfield		22d. LOCATION (City, town, or county) (State) Sykesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Wright - Sykesville, Md.				24a. REC'D BY REGISTRAR DATE 7-10-56		24b. REGISTRAR'S SIGNATURE E. Harry W...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07064

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7092

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>FLORENCE ELIZABETH HORSEY</u>		4. DATE OF DEATH <u>July 20 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/20/181</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-30-28583</u>	
17. INFORMANT <u>Harry Lewis Horsey</u>		Address <u>Sykesville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C-V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>422.1</u> (c), stating the underlying cause last. (c) <u>422.1</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type or print) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>7/21/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 23, 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Johnsville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Johnsville, Carroll Co, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u>		24a. REC'D BY REGISTRAR <u>W. Ingrid, Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harry Hays</u>		DATE <u>23 1956</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

JUL 23 1956

BUREAU V. B.

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07065

7093

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 11y, 8mos. 3days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1602 Ellamont Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle KAHL Last KAHL		4. DATE OF DEATH Month July Day 19 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23, 1863
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months 19 Days 19 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY 7/11/11	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Kahl		14. MOTHER'S MAIDEN NAME Christina Wise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 7-11-11	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the left parotid gland with metastases 142.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 142.1 DUE TO (c) 142.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease, with psychosis, with cerebral arterio-sclerosis. INTERVAL BETWEEN ONSET AND DEATH Months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 , 19 50 , to July 19 , 19 56 , that I last saw the deceased alive on July 19 , 19 56 , and that death occurred at 8:20 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		DATE SIGNED 7/19/56	
22a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-21-56	
22c. NAME OF CEMETERY OR CREMATORY LONDON PK		22d. LOCATION (City, town, or county) (State) BALTO. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc 1217 ST PAUL ST		24a. REC'D BY REGISTRAR DATE 7-20-56	
24b. REGISTRAR'S SIGNATURE C. Harry Allen			

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BUREAU V. S.

JUL 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7094

CERTIFICATE OF DEATH

07066

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1yr. 11mos. 2dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 411 Lyndhurst St., Balto. 29.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle James Last KERNAN				4. DATE OF DEATH Month July Day 11 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/10/74	
9. AGE (In years last birthday) 81 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Michael J. Kernan		14. MOTHER'S MAIDEN NAME Isabel Ackenback			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Springfield Hospital records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. MOCK (c) Gangrene of left foot							INTERVAL BETWEEN ONSET AND DEATH Minutes Years 2 wks. plus
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involuntional psychotic reaction; and C.B.S. asso. with dist. of metabolism, growth or nut. with senile br. dis. with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 2, 1954 , to July 11, 1956 , that I last saw the deceased alive on July 11, 1956 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 7/11/56	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/14/56		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ann Cook, Inc.				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR July 13, 1956	
				24b. REGISTRAR'S SIGNATURE C. Harry News			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES H. HARRIS		MALE		38		JULY 13 1956	
PLACE OF DEATH		CITY		STATE		COUNTY	
BALTIMORE		BALTIMORE		MARYLAND		BALTIMORE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT	
LABORER		HEART DISEASE		NATURAL		BALTIMORE	
DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
JULY 13 1956		JULY 13 1956		10:00 AM		10:00 AM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
JUL 13 1956
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

74

7095

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4 mos.; 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1932 Pearlman Pl. 2327 N. Charles Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Johanna Middle Kemelk Last KORB				4. DATE OF DEATH Month July Day 17 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1880	
9. AGE (In years last birthday) 76 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? Unknown				13. FATHER'S NAME Karl Kemelk			
14. MOTHER'S MAIDEN NAME Carlin - (Unknown)				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. -				17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) 420.0							INTERVAL BETWEEN ONSET AND DEATH 1 day years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with semile brain disease with psychotic reaction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 12, 1956 , to July 17, 1956 , that I last saw the deceased alive on July 17, 1956 , and that death occurred at 10:55A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Walther H. Sonnenfeldt M.D. Springfield State Hospital 7/17/56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 20 1956		22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM		22d. LOCATION (City, town, or county) (State) 4430 BELAIR RD M D	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. P. Bros. 1800 E Lombard St				24a. REC'D BY REGISTRAR JUL 20 1956		24b. REGISTRAR'S SIGNATURE Anthony Hays	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Res.: By phone to Melchor Nursing Home....7/20/56 ams

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BUREAU V. B.

JUL 20 1956

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7096

CERTIFICATE OF DEATH

Reg. Dist. No. 07068 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 8 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. STREET ADDRESS 764 W. Hamburg Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mabel Middle E Last Kuhn				4. DATE OF DEATH Month July Day 23 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-23-08	
9. AGE (In years lost birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Stiner				14. MOTHER'S MAIDEN NAME Mary Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage with pulmonary edema 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with post-infectious encephalitis Parkinsonism							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-20 , to 7-23 , that I last saw the deceased alive on 7-23 , 19 56 , and that death occurred at 1:15 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Springfield State Hospital				DATE SIGNED 7/23/56			
ACTUAL SIGNATURE Gertrud Sonnenfeldt M.D.							
PHYSICIAN'S NAME (Type) Gertrud Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/26/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem		22d. LOCATION (City, town, or county) (State) 5501 Frederick Ave	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Brown				24a. RECEIVED BY REGISTRAR JUL 26 1956		24b. REGISTRAR'S SIGNATURE C. Harry Kear	

CERTIFICATE OF DEATH

7-28

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		10-1-1910		New York, N.Y.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Home	
Date of Death		Time of Death		Place of Death		Physician's Signature		Hospital or Institution	
7-28-56		10:15 AM		Home		J. Doe, M.D.		St. Mary's Hospital	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Medical Examiner	
J. Doe, M.D.		A. Smith, Registrar		B. Jones, Informant		C. Brown, Coroner		D. White, Medical Examiner	

BUREAU V. E.

JUL 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07069

7097

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS R.D. # 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle W. Last LOWMAN				4. DATE OF DEATH Month JULY Day 30 Year 1956			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-1897		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Springfield S.Hosp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lowman				14. MOTHER'S MAIDEN NAME Fannie Berry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -- -- -- --		17. INFORMANT Mrs. Bessie Lowman, Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/30/56	
EXAMINER'S NAME (Type) JAMES T. MARSH				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-2-1956		22c. NAME OF CEMETERY OR CREMATORY White Rock		22d. LOCATION (City, town, or county) (State) Carroll Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DATE 7-31-56	
						24b. REGISTRAR'S SIGNATURE C. Harry [unclear]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		ATTORNEY AT LAW	
LAST KNOWN ADDRESS		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL EXAMINER'S SIGNATURE	
3121 1/2 E. CARROLL AVE., BALTIMORE, MD.		JUN 6 1968		BALTIMORE, MD.		HEART DISEASE - CORONARY ARTERY DISEASE		NATURAL		JAMES EARL RAY	
PREVIOUS MEDICAL HISTORY		DATE OF EXAMINATION		PLACE OF EXAMINATION		FINDINGS		REMARKS		SIGNATURE OF PHYSICIAN	
HYPERTENSION, CHOLESTEROL		JUN 5 1968		BALTIMORE, MD.		HEART DISEASE - CORONARY ARTERY DISEASE		NATURAL		JAMES EARL RAY	
TREATMENT		DATE OF TREATMENT		PLACE OF TREATMENT		FINDINGS		REMARKS		SIGNATURE OF PHYSICIAN	
DIGITALIS, DIURETICS		JUN 5 1968		BALTIMORE, MD.		HEART DISEASE - CORONARY ARTERY DISEASE		NATURAL		JAMES EARL RAY	
DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION	
JUN 5 1968		JUN 5 1968		JUN 5 1968		JUN 5 1968		JUN 5 1968		JUN 5 1968	

BUREAU V. E.

AUG 5 1966

RECEIVED

7973

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 251 E. MAIN		d. STREET ADDRESS 251 E. MAIN	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES GLOTT LYNCH		4. DATE OF DEATH JULY 30 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 14, 1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEC. + TREAS. CARROLL CO. MUTUAL FINS.		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL EDWARD LYNCH		14. MOTHER'S MAIDEN NAME MARGARET DIFFENDAL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-9937	
17. INFORMANT EMILT GRENDOFF LYNCH		Address 251 E. MAIN WESTMINSTER MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X acute Cardiac Decompensation DUE TO (b) Lobar Pneumonia DUE TO (c) cardiac Renal Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 6 hrs 3 days 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture Rt Femur Intracapsular 1934		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25, 1956 to July 30, 1956 , that I last saw the deceased alive on July 30, 1956 , and that death occurred at 2:30 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Westminster MD. DATE SIGNED 7.31.56	
ACTUAL SIGNATURE Chas. R. Foutz		PHYSICIAN'S NAME (Type) Chas. R. Foutz	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-2-1956	
22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) WESTMINSTER MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ABANDARDY SON WESTMINSTER, MD		ADDRESS MD.	
24a. REC'D BY REGISTRAR DATE 8-2-56		24b. REGISTRAR'S SIGNATURE Harriet Miller	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07071

7074 CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER	
c. LENGTH OF STAY IN 1b 84 YRS.		d. STREET ADDRESS S. CENTER ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION IBEX BOARDING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JACOB Middle WESLEY Last MATHIAS		4. DATE OF DEATH Month JULY Day 25 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 6 1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 4 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER, PET. WATER CO.		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPHUS MATHIAS		14. MOTHER'S MAIDEN NAME ELIZA WISE HAUR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-9113	
17. INFORMANT J. WESLEY MATHIAS WESTMINSTER, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 420.1 DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of bladder		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1953 to July 25, 1956 that I last saw the deceased alive on July 20, 1956 and that death occurred at 5 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 7/26/56	
ACTUAL SIGNATURE E. Reese Wilkens		PHYSICIAN'S NAME (Type) E. Reese Wilkens	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-27-1956	
22c. NAME OF CEMETERY OR CREMATORY TRIDERS CEMETERY		22d. LOCATION (City, town, or county) (State) WESTMINSTER MD.	
23. FUNERAL DIRECTOR'S SIGNATURE H. BARKARD & SON		ADDRESS WESTMINSTER MD.	
24a. REC'D BY REGISTRAR DATE 7-30-56		24b. REGISTRAR'S SIGNATURE Harold Miller	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **87072 74**

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Life		e. STREET ADDRESS Hodges Road	
3. NAME OF DECEASED (Type or print) First DONALD Middle MOAKS Last MOAKS		4. DATE OF DEATH Month July Day 27 Year 1956	
5. SEX M	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-1940
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scholar		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George B. Moaks, Jr.		14. MOTHER'S MAIDEN NAME Mary C. Quickley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Geo. Moaks - Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned in creek while bathing	
20c. TIME OF INJURY Month, Day, Year 4 7/27 1956 Hour 8 p. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ELDERSBURG	20f. (City or town) (County) (State) Carroll Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James J. Moroh		DATE SIGNED 7/27/56	
EXAMINER'S NAME (Type) JAMES T. MARSH		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Long Green	22d. LOCATION (City, town, or county) (State) Baltimore Co, Md
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Haight		24a. REC'D BY REGISTRAR 7-29-56	
ADDRESS Sykesville, Md		24b. REGISTRAR'S SIGNATURE C. Harry W...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 2 1956
BUREAU V. 3

Form with multiple sections and fields, including checkboxes and text areas, mostly illegible due to fading and bleed-through. Visible text includes "RECEIVED", "AUG 2 1956", and "BUREAU V. 3".

CERTIFICATE OF DEATH

Reg. Dist. No. 74

7099

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Liberty Road</u>			
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>ELIZABETH</u> Middle <u>Phillips</u> Last <u>July</u>				4. DATE OF DEATH <u>July 27</u> 19 <u>56</u>			
5. SEX <u>♀</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1902</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver E. Phillips</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Reese</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Katherine Phillips Sykesville</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heavenly intervention</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain tumor (malignant)</u> DUE TO (c) <u>?</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7/19/56</u> , 19 <u>56</u> , to <u>7/26/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/26/56</u> , 19 <u>56</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. E. Martin</u>				ADDRESS (Street, city or town, state) <u>Randallstown Md.</u> DATE SIGNED <u>7/28/56</u>			
PHYSICIAN'S NAME (Type) <u>Wm. E. Martin</u>				<u>RANDALLSTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Oakland</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight - Sykesville</u> ADDRESS				24a. REC'D BY REGISTRAR <u>7-28-56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>C. Harry Weir</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE	
22. SIGNATURE OF JAILER		23. SIGNATURE OF PRISONER		24. SIGNATURE OF WARDEN	
25. SIGNATURE OF CHIEF OF POLICE		26. SIGNATURE OF DETECTIVE		27. SIGNATURE OF OFFICER	
28. SIGNATURE OF SQUAD LEADER		29. SIGNATURE OF DRIVER		30. SIGNATURE OF MECHANIC	
31. SIGNATURE OF TOWER		32. SIGNATURE OF REPAIRMAN		33. SIGNATURE OF PAINTER	
34. SIGNATURE OF CARPENTER		35. SIGNATURE OF ELECTRICIAN		36. SIGNATURE OF PLUMBER	
37. SIGNATURE OF ROOFER		38. SIGNATURE OF GARDENER		39. SIGNATURE OF LANDSCAPER	
40. SIGNATURE OF FLOWER SELLER		41. SIGNATURE OF SEED SELLER		42. SIGNATURE OF FERTILIZER SELLER	
43. SIGNATURE OF PESTICIDE SELLER		44. SIGNATURE OF IRRIGATION SELLER		45. SIGNATURE OF FENCE SELLER	
46. SIGNATURE OF TOOL SELLER		47. SIGNATURE OF EQUIPMENT SELLER		48. SIGNATURE OF SUPPLY SELLER	
49. SIGNATURE OF SERVICE STATION		50. SIGNATURE OF AUTO REPAIR SHOP		51. SIGNATURE OF TIRE SHOP	
52. SIGNATURE OF OIL CHANGING		53. SIGNATURE OF CAR WASH		54. SIGNATURE OF CAR DETAILING	
55. SIGNATURE OF CARPENTRY		56. SIGNATURE OF PAINTING		57. SIGNATURE OF ROOFING	
58. SIGNATURE OF SIDERING		59. SIGNATURE OF GUTTERING		60. SIGNATURE OF DRAPERY	
61. SIGNATURE OF CURTAIN		62. SIGNATURE OF FURNITURE		63. SIGNATURE OF APPLIANCE	
64. SIGNATURE OF ELECTRONICS		65. SIGNATURE OF TELEVISION		66. SIGNATURE OF RADIO	
67. SIGNATURE OF MUSIC		68. SIGNATURE OF BOOKS		69. SIGNATURE OF RECORDS	
70. SIGNATURE OF MOVIES		71. SIGNATURE OF GAMES		72. SIGNATURE OF TOYS	
73. SIGNATURE OF CLOTHING		74. SIGNATURE OF SHOES		75. SIGNATURE OF ACCESSORIES	
76. SIGNATURE OF JEWELRY		77. SIGNATURE OF COSMETICS		78. SIGNATURE OF HAIR	
79. SIGNATURE OF NAILS		80. SIGNATURE OF SKIN		81. SIGNATURE OF EYES	
82. SIGNATURE OF EARS		83. SIGNATURE OF NOSE		84. SIGNATURE OF MOUTH	
85. SIGNATURE OF TEETH		86. SIGNATURE OF TONGUE		87. SIGNATURE OF THROAT	
88. SIGNATURE OF NECK		89. SIGNATURE OF CHEST		90. SIGNATURE OF STOMACH	
91. SIGNATURE OF LIVER		92. SIGNATURE OF PANCREAS		93. SIGNATURE OF SPLEEN	
94. SIGNATURE OF LUNG		95. SIGNATURE OF HEART		96. SIGNATURE OF BLOOD	
97. SIGNATURE OF URINE		98. SIGNATURE OF FECES		99. SIGNATURE OF SWEAT	
100. SIGNATURE OF TEARS		101. SIGNATURE OF SALIVA		102. SIGNATURE OF SPIT	
103. SIGNATURE OF SNEEZE		104. SIGNATURE OF CRY		105. SIGNATURE OF SMILE	
106. SIGNATURE OF LAUGH		107. SIGNATURE OF SHOUT		108. SIGNATURE OF WHISPER	
109. SIGNATURE OF SING		110. SIGNATURE OF DANCE		111. SIGNATURE OF WALK	
112. SIGNATURE OF RUN		113. SIGNATURE OF JUMP		114. SIGNATURE OF FALL	
115. SIGNATURE OF CLIMB		116. SIGNATURE OF CRAWL		117. SIGNATURE OF SLIP	
118. SIGNATURE OF TRIP		119. SIGNATURE OF FALL		120. SIGNATURE OF CRASH	

BUREAU V. S.

AUG 2 1956

RECEIVED

7100

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 19 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 618 S. Washington Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				3V01-4			
3. NAME OF DECEASED (Type or print) Mary First Middle Last Pumphrey				4. DATE OF DEATH Month July Day 11 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-26-1875	
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing house worker				10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Baty				14. MOTHER'S MAIDEN NAME Eleanor Smart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. unk		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure DUE TO (b) Arteriosclerosis DUE TO (c) Schizophrenia, paranoid type PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, paranoid type							
INTERVAL BETWEEN ONSET AND DEATH 2 hours 18 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 2-23 , 19 37 , to 7-11 , 19 56 , that I last saw the deceased alive on 7-11 , 19 56 , and that death occurred at 2:18 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED							
ACTUAL SIGNATURE Gertrud Sourenfeldt M.D.				PHYSICIAN'S NAME (Type) Gertrud Sourenfeldt			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-14-56		Cedar Hill		A. A. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight ADDRESS Hydenville, Md.				24a. REC'D BY REGISTRAR DATE 7-13-56		24b. REGISTRAR'S SIGNATURE C. Harry Weese	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7101

CERTIFICATE OF DEATH

07075

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 7mos. 11 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 2913 Kirk Avenue, Zone 18	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charlotte Elizabeth F. RELLEKER		4. DATE OF DEATH Month Day Year July 10 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1884
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Fritzes		14. MOTHER'S MAIDEN NAME Dora Seebach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No - -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. asso. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days plus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 29 , 19 55 , to July 10 , 19 56 , that I last saw the deceased alive on July 10 , 19 56 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Walther H. Sonnenfeldt M.D. Springfield State Hospital 7/11/56 PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jul. 14, 1956	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Baltimore Md.		24a. REC'D BY REGISTRAR See J. Bander DATE JUL 12 1956	
24b. REGISTRAR'S SIGNATURE C. Harry Keay			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		JAN 24 1928		MEMPHIS TENN		MEMPHIS TENN		UNITED STATES	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		JAN 1950		MEMPHIS		MEMPHIS		UNITED STATES		JAN 4 1968		MEMPHIS		MEMPHIS	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
CONTRACTOR		JAN 1950		MEMPHIS		MEMPHIS		UNITED STATES		JAN 4 1968		MEMPHIS		MEMPHIS	
CAUSE OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		JAN 1950		MEMPHIS		MEMPHIS		UNITED STATES		JAN 4 1968		MEMPHIS		MEMPHIS	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
NATURAL		JAN 1950		MEMPHIS		MEMPHIS		UNITED STATES		JAN 4 1968		MEMPHIS		MEMPHIS	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAMES EARL RAY		JAN 1950		MEMPHIS		MEMPHIS		UNITED STATES		JAN 4 1968		MEMPHIS		MEMPHIS	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAMES EARL RAY		JAN 1950		MEMPHIS		MEMPHIS		UNITED STATES		JAN 4 1968		MEMPHIS		MEMPHIS	

BUREAU V. S.

JUL 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7102

CERTIFICATE OF DEATH

07076
14

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flohrville</u>		c. LENGTH OF STAY IN 1b <u>45 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flohrville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Sylvanville P.O.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD H. C. REYNOLDS</u>				4. DATE OF DEATH Month Day Year <u>July 17 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-8-1874</u>		9. AGE (in years last birthday) yrs. Months Days Hours Min. <u>82</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ymk.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Isaac Reynolds</u>				14. MOTHER'S MAIDEN NAME <u>Julia Alexander</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-05-7819</u>		17. INFORMANT Address <u>William H. Reynolds - Sylvanville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, arteriosclerotic heart dis.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pulmonary emphysema, malnutrition,</u> DUE TO (c) <u>anemia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1951</u> <u>17 July 56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19 <u> </u> , to <u>July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>16 July</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Sylvanville, Md.</u>		DATE SIGNED <u>17 July 56</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wards Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Flohrville Rd - Bald Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Sylvanville, Md.</u>				24a. REC'D BY REGISTRAR <u>7-17-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Ewer</u>	

BUREAU V. S.

JUL 20 1956

RECEIVED

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

67077

7103

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 6y; 11mos. 27da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3523 Oakmont Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fanchon Middle O. Last SCHIEBEL				4. DATE OF DEATH Month July Day 19 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 9, 1877	
9. AGE (In years last birthday) 79 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Grey				14. MOTHER'S MAIDEN NAME Elizabeth Gamber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [Illegible]		17. INFORMANT Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Springfield				20g. (County) Carroll		20h. (State) Maryland	
21. I certify that I attended the deceased from Oct. 20 , 19 54 , to July 19 , 19 56 , that I last saw the deceased alive on July 19 , 19 56 , and that death occurred at 12:46 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/19/56 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23, 1956		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. K. Korman				ADDRESS 4611 Park Heights, Balto.		24a. REC'D BY REGISTRAR JUL 23 1956	
24b. REGISTRAR'S SIGNATURE Harry Kump							

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

80

RECEIVED

9551

5. A. 11-12-42

Figure 1

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7105

CERTIFICATE OF DEATH

07078

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b since 1/20/55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jacob Middle - Last SHAPIRO				4. DATE OF DEATH Month July Day 26 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 8, 1890	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 6 Days 15 Hours 15 Min.		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? unknown							
13. FATHER'S NAME David Shapiro				14. MOTHER'S MAIDEN NAME Dora -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records of Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 410 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral stenosis DUE TO (c) -				INTERVAL BETWEEN ONSET AND DEATH minutes more than 20 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hebephrenic schizophrenic				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	
20f. (City or town) (County) (State) -							
21. I certify that I attended the deceased from Sept. 1st , 19 47 , to July 26th , 19 56 , that I last saw the deceased alive on July 26 , 19 56 , and that death occurred at 7:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Mari Snn				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 7/27/56							
PHYSICIAN'S NAME (Type) Martin Gross, M. D.				Sykesville, Carroll Co., Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/56		22c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Solomonson Bros Inc				ADDRESS 1124-26 W. North Ave			
24a. REC'D BY REGISTRAR C. Harry Myers				24b. REGISTRAR'S SIGNATURE C. Harry Myers			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

JUL 30 1956

RECEIVED

7075

CERTIFICATE OF DEATH

67079

Reg. Dist. No.

26

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 144 Washington Road				d. STREET ADDRESS 144 Washington Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle Allen Last Siegmán				4. DATE OF DEATH Month July Day 30 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1955	
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 30 Hours 56		IF UNDER 24 HRS. Months 1 Days 30 Hours 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home				10b. KIND OF BUSINESS OR INDUSTRY child		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME George C. Siegman				14. MOTHER'S MAIDEN NAME Helen Chamberlin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give year or dates of service) no			
17. INFORMANT George C. Siegman				Address Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Reticulo endotheliosis 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 6 1/2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to July 30, 19 56 , that I last saw the deceased alive on July 30, 19 56 , and that death occurred at 11:45 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James T. Marsh M.D.				ADDRESS (Street, city or town, state) Westminster DATE SIGNED Jul 31/56			
PHYSICIAN'S NAME (Type) James T. Marsh, M.D. 109 E. Main St. Westminster, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/2/56		22c. NAME OF CEMETERY OR CREMATORY Leister's Cemetery		22d. LOCATION (City, town, or county) (State) near Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE 8-3-56	
24b. REGISTRAR'S SIGNATURE Harold Müller							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

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CERTIFICATE OF DEATH

Reg. Dist. No. 74

7106

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 7mos., 26days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Andrew Last SNYDER				4. DATE OF DEATH Month July Day 19 Year 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1878	
9. AGE (In years less birthday) yrs. 77		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leather goods worker		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME George A. Snyder			
14. MOTHER'S MAIDEN NAME Elizabeth - Little				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 214-09-8444				17. INFORMANT Address Springfield Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocardial infarction (c) Chronic cystitis.							INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. asso. with circ. dist., with cereb. arteriosclerosis with psychotic reaction. Old organized subdural hemorrhage. Epithelioma of lower lip.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov. 23, 1955 , to July 19, 1956 , that I last saw the deceased alive on July 19, 1956 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED ACTUAL SIGNATURE Agustin del Campo M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Agustin DelCampo, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-22-56		22c. NAME OF CEMETERY OR CREMATORY Beautiful View	
22d. LOCATION (City, town, or county) (State) State Line Pa.				23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fred W. Kraiss Hagerstown, Md.			
24a. REC'D BY REGISTRAR DATE 7-22-56				24b. REGISTRAR'S SIGNATURE C. Harry Allen			

CERTIFICATE OF DEATH

DECEASED EYESSIELE		MARRIAGE JESSIE K. KAY	
PLACE OF BIRTH Maryland State Hospital		PLACE OF BIRTH Maryland State Hospital	
DATE OF BIRTH July 19, 1910		DATE OF BIRTH July 19, 1910	
SEX Male		SEX Male	
RACE White		RACE White	
OCCUPATION Teacher grade school		OCCUPATION Teacher grade school	
PLACE OF DEATH Baltimore - State		PLACE OF DEATH Baltimore - State	
DATE OF DEATH Nov. 23, 1956		DATE OF DEATH Nov. 23, 1956	
TIME OF DEATH 11:00 AM		TIME OF DEATH 11:00 AM	
CAUSE OF DEATH Myocardial infarction		CAUSE OF DEATH Myocardial infarction	
MANNER OF DEATH Natural		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. H. KAY		SIGNATURE OF PHYSICIAN J. H. KAY	
SIGNATURE OF WITNESS J. H. KAY		SIGNATURE OF WITNESS J. H. KAY	
SIGNATURE OF DECEASED J. H. KAY		SIGNATURE OF DECEASED J. H. KAY	

RECEIVED
 JUL 25 1956
 BUREAU V. 1

CERTIFICATE OF DEATH

Reg. Dist. No. 24

7107

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 8 mos. 14da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Harper Zohn WADE		4. DATE OF DEATH Month July Day 2 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Zohn		14. MOTHER'S MAIDEN NAME Grace Withmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 7-14	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular syphilis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. asso. with circ. dist., other than cerebral arteriosclerosis, with			INTERVAL BETWEEN ONSET AND DEATH 5 hrs. plus Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) psychotic reaction, with systemic syphilis.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 18, 19 54 , to July 2, 19 56 , that I last saw the deceased alive on July 2, 19 56 , and that death occurred at 6:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/3/56 ACTUAL SIGNATURE Walther H. Sonnenfeldt PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF July-6-1956	22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY	22d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE BAST FUNERAL HOME		24a. REC'D BY REGISTRAR Boonsboro MD.	24b. REGISTRAR'S SIGNATURE C. Harry Ware

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Mary Harper John		Female		65		May 2, 1887		Maryland		Maryland		Heart Disease		May 2, 1956		10:00 AM		Home		J. H. Smith		J. H. Smith	

BUREAU V. S.

JUL 9 1956

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CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. LENGTH OF STAY IN 1b <i>14 months</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Emma</i> Middle <i>I</i> Last <i>WARD</i>				4. BASE OF DEATH Month <i>July</i> Day <i>28</i> Year <i>1956</i>			
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1, 1871</i>	9. AGE in years last birthday <i>85</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School teacher</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Teaching</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>William J. Galt</i>				14. MOTHER'S MAIDEN NAME <i>Mary Harding</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Mr. Charles Kemp Sykesville, md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Cardiac Arrest, arteriosclerotic heart dis.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Conjunctive failure, edema-</i> DUE TO <i>arricular fibrillation</i> (c) <i>arricular fibrillation</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1954 July 56</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>March</i> , 1954, to <i>July</i> , 1956, that I last saw the deceased alive on <i>27 July</i> , 1956, and that death occurred at <i>8:25 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Howard E. Hall</i> M.D.				ADDRESS (Street, city or town, state) <i>Sykesville, md</i> DATE SIGNED <i>28 July 56</i>			
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>				SYKESVILLE, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-30-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove</i>		22d. LOCATION (City, town, or county) (State) <i>Glenwood, Howard, md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Luther H. Haight</i> ADDRESS <i>Sykesville, md.</i>				24a. REC'D BY REGISTRAR DATE <i>7-28-56</i>		24b. REGISTRAR'S SIGNATURE <i>C. Harry Wier</i>	

BUREAU V. J.

AUG 2 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07083

7109

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linebors</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linebors</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>CARROLL-G-WAREHEIM</u> First Middle Last		4. DATE OF DEATH <u>July 8</u> 19 <u>56</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 26-1884</u> 71 yrs. last birthday
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canner</u>	
13. FATHER'S NAME <u>Geo R Wareheim</u>		14. MOTHER'S MAIDEN NAME <u>Alveta Gardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-77361</u>	
17. INFORMANT <u>Mrs Carroll Wareheim</u> Address <u>Linebors Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral Arterio-Sclerosis</u> DUE TO (c) <u>9410</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 15, 1947</u> , to <u>July 8, 1956</u> , that I last saw the deceased alive on <u>July 8, 1956</u> , and that death occurred at <u>1:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u> DATE SIGNED <u>7/9/56</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		<u>Hampstead, Md.</u> <u>7/9/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 11/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Linebors</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Lipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Mrs. H.P.S. Sauer</u> DATE <u>July 11/56</u>	

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film G201 8-6-56 et

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7076

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. LENGTH OF STAY IN 1b 4 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glover Nursing Home				d. STREET ADDRESS Unknown			
3. NAME OF DECEASED (Type or print) First Nettie Middle Lydia Rebecca Last Warner				4. DATE OF DEATH Month July Day 21 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1878		9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR Months 1 Days 9	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Null				14. MOTHER'S MAIDEN NAME Mary Sweidner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Wm. Warner, Frizzleburg, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic C-V disease DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 24 hr years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 20, 1956 to July 20, 1956 , that I last saw the deceased alive on July 20, 1956 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE James J. Marsh				ADDRESS (Street, city or town, state) Westminster Md		DATE SIGNED 7/21/56	
PHYSICIAN'S NAME (Type) JAMES T. MARSH							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-23-56		22c. NAME OF CEMETERY OR CREMATORY Fairmount Cemetery		22d. LOCATION (City, town, or county) (State) Liberty Town, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin				ADDRESS Martin Funeral Home, Manchester, Md		24a. REC'D BY REGISTRAR JUL 27 1956	
				24b. REGISTRAR'S SIGNATURE Harriet Mallery			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 1920	
5. PLACE OF BIRTH Missouri		6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White	
9. PLACE OF DEATH Baltimore, Maryland		10. CAUSE OF DEATH Suicide		11. MANNER OF DEATH Homicide		12. DATE OF DEATH June 4, 1968	
13. PLACE OF INTERMENT None		14. NAME OF FUNERAL HOME None		15. SIGNATURE OF DECEASED None		16. SIGNATURE OF WITNESSES None	
17. SIGNATURE OF REGISTRAR None		18. OFFICIAL SEAL None		19. COUNTY None		20. STATE None	

BUREAU V. 3

JUL 27 1968

RECEIVED

7110

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>2y 5mo 27 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>3104 Ellerslie Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick Ignatius Wills</u>		4. DATE OF DEATH <u>7-29</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-77</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Penning</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Wills</u>		14. MOTHER'S MAIDEN NAME <u>Mary Teresa</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT Address <u>Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491x</u> DUE TO <u>bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. associated with senile changes of the brain with psychosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 2, 1953</u> to <u>July 29, 1956</u> , that I last saw the deceased alive on <u>July 28, 1956</u> , and that death occurred at <u>3:04 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt</u>		DATE SIGNED <u>7/29/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-1-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>335 N. York Rd</u>	
24a. REC'D BY REGISTRAR <u>DATE 7-29-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Henry Wren</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7111

CERTIFICATE OF DEATH

07086
Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>47 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>E. Edinburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>R</u> Last <u>WILSON</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-1908</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Mamie E. Shipley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs. R. R. Wilson - Sykesville, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIAL, MYOCARDITIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY THROMBOSIS, CONGESTIVE</u> DUE TO (c) <u>HEART FAILURE.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>MAY 56</u> <u>JULY 56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>56</u> , to <u>JULY</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>30 JUNE</u> , 19 <u>56</u> , and that death occurred at <u>4: A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>SYKESVILLE, MD</u>		DATE SIGNED <u>1 JULY 56</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-3-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Oakland</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight - Sykesville, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>7-1-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Wier</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7112

CERTIFICATE OF DEATH

070874
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eldersburg</u>	c. LENGTH OF STAY IN 1b <u>69 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eldersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Chickenville P.O.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>J</u> Last <u>WOBERT</u>		4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-16-1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building Homes</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George W. Wolbert</u>	
14. MOTHER'S MAIDEN NAME <u>Alberta Worsey</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u> </u>	
16. SOCIAL SECURITY NO. <u>217-07-2293</u>		17. INFORMANT <u>Mr. Annie Wolbert, Chickenville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC Arrest, CARCINOMA of prostate</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized metastases, anemia,</u> DUE TO (c) <u>renal metastases.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1955</u> ↓ <u>July 56</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>55</u> to <u>July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>18 July</u> , 19 <u>56</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u>		ADDRESS (Street, city or town, state) <u>Applawton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		DATE SIGNED <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-22-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Morgan Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Woodbine, Carroll, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight, Chickenville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7-20-56</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry Wilson</u>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	

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 BUREAU V. 3

7113

CERTIFICATE OF DEATH

Reg. Dist. No.

82-83

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Ave. at Oak St.</u>		d. STREET ADDRESS <u>Maple Ave at Oak St</u>	
3. NAME OF DECEASED (Type or print) <u>Harry Clyde Wright</u>		4. DATE OF DEATH <u>July 3 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Form</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Albert Wright</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Elmira Stansfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-24-6179</u>	
17. INFORMANT <u>Mrs H. Clyde Wright</u>		Address <u>Mt. Airy, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>more than 5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>51</u> , to <u>July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 3</u> , 19 <u>56</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u>		DATE SIGNED <u>July 3, 1956</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		ADDRESS (Street, city or town, state) <u>Mount Airy, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-6-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARMONY</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Waetz</u>		24a. REC'D BY REGISTRAR <u>Robert R. Hewitt</u>	
ADDRESS <u>Winfield, Md.</u>		DATE <u>7-6-56</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1118

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
JAMES H. HARRIS		Male		45		1911		Maryland		1966		Baltimore		Heart Disease		Natural		J. H. Harris		J. H. Harris		July 9, 1966	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Signature of informant		21. Signature of registrar		22. Date of registration		23. Date of death		24. Date of burial	
J. H. Harris		Wife		1234 Main St.		Baltimore		Maryland		21201		(410) 555-1234		J. H. Harris		J. H. Harris		July 9, 1966		July 9, 1966		July 10, 1966	

BUREAU V. 8

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07089

7114

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster				c. LENGTH OF STAY IN 1b 18 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle WASHINGTON Last YOUNG				4. DATE OF DEATH Month JULY Day 27 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-27-1881	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Young				14. MOTHER'S MAIDEN NAME Elizabeth Ann Frizzell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-03-6919		17. INFORMANT Address Mrs. Sarah Jane Young, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis, Hypertension DUE TO (c) - Sion & Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH Several hrs 54 hrs 54 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 1956 to July 27, 1956 , that I last saw the deceased alive on July 27, 1956 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Glenn Speicher				ADDRESS (Street, city or town, state) Westminster Md.			
PHYSICIAN'S NAME (Type) W. Glenn Speicher				DATE SIGNED July 28-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-31-1956		22c. NAME OF CEMETERY Taylorville		22d. LOCATION (City, town, or county) (State) Carroll CO. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE 7-31-56	
				24b. REGISTRAR'S SIGNATURE Harold B. Miller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

2 AUG 2 1956

BUREAU V. F.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7115 CERTIFICATE OF DEATH

07090

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Maryland COUNTY Carroll		CITY (If outside corporate limits, write RURAL and give nearest town) Finksburg		CITY (If outside corporate limits, write RURAL and give nearest town) Finksburg	
CITY (If outside corporate limits, write RURAL and give nearest town) Finksburg		LENGTH OF STAY (In this place) 1 year		TOWN Finksburg		TOWN Finksburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedarhurst Road				STREET ADDRESS (If rural give location) Cedarhurst Road			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Mary Elizabeth Zanders				4. DATE OF DEATH (Month) (Day) (Year) July 14 1956			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 23 1871	9. AGE last birthday 85 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Gittings				14. MOTHER'S MAIDEN NAME Elizabeth Mitchell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Alva Brooks Finksburg Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Ruptured Esophageal Varicose Vein						INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
ANTECEDENT CAUSE(S) DUE TO (B) CIRRHOSIS OF LIVER						YEARS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) ARTERIOSCLEROTIC C.V. DISEASE WITH						YEARS	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CARDIAC DECOMPENSATION							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from MARCH, 1942 , to JULY 14, 1956 , that I last saw the deceased alive on JULY 14, 1956 , and that death occurred at 7 P.M. , from the causes and on the date stated above.							
SIGNATURE Martin E. Strobel				DATE SIGNED 7/16/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF July 18 1956		NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24. REC'D BY REGISTRAR 7-18-56				REGISTRAR'S SIGNATURE Mary B. Elino		25. FUNERAL DIRECTOR'S SIGNATURE Reisterstown Md	
DATE				ADDRESS			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16

11/15/56

Reg. Dist. No. 1

1. NAME OF DECEASED

CHARLES WILLIAM

2. SEX

MALE

3. AGE

35

4. DATE OF BIRTH

11/15/21

5. PLACE OF BIRTH

BALTIMORE, MARYLAND

6. OCCUPATION

LABORER

7. CAUSE OF DEATH

HEART DISEASE

8. PLACE OF DEATH

BALTIMORE, MARYLAND

9. TIME OF DEATH

11:00 PM

10. SIGNATURE OF PHYSICIAN

DR. J. H. SMITH

11. SIGNATURE OF REGISTRAR

MR. J. H. SMITH

12. SIGNATURE OF WITNESSES

MR. J. H. SMITH

13. SIGNATURE OF DECEASED

CHARLES WILLIAM

14. SIGNATURE OF DECEASED

CHARLES WILLIAM

15. SIGNATURE OF DECEASED

CHARLES WILLIAM

16. SIGNATURE OF DECEASED

CHARLES WILLIAM

17. SIGNATURE OF DECEASED

CHARLES WILLIAM

18. SIGNATURE OF DECEASED

CHARLES WILLIAM

19. SIGNATURE OF DECEASED

CHARLES WILLIAM

20. SIGNATURE OF DECEASED

CHARLES WILLIAM

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CHARLES WILLIAM

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BALTIMORE, MARYLAND

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CHARLES WILLIAM

15. SIGNATURE OF DECEASED

CHARLES WILLIAM

16. SIGNATURE OF DECEASED

CHARLES WILLIAM

17. SIGNATURE OF DECEASED

CHARLES WILLIAM

18. SIGNATURE OF DECEASED

CHARLES WILLIAM

19. SIGNATURE OF DECEASED

CHARLES WILLIAM

20. SIGNATURE OF DECEASED

CHARLES WILLIAM

21. SIGNATURE OF DECEASED

CHARLES WILLIAM

22. SIGNATURE OF DECEASED

CHARLES WILLIAM

23. SIGNATURE OF DECEASED

CHARLES WILLIAM

RECEIVED

BUREAU V. 1

JUL 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07091

CERTIFICATE OF DEATH

Reg. Dist. No. 70

7116

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>	
c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>W.</u> Last <u>Zepp</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>19 56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1877</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse Myers</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Witmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Clifton Zepp, Taneytown, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 30</u> , 19 <u>56</u> , to <u>July 31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 30</u> , 19 <u>56</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph R. John, M.D.</u>		ADDRESS (Street, city or town, state) <u>49 Frederick St Taneytown, Md.</u> DATE SIGNED <u>8/3/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 3, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pleasant Valley, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Suss</u> ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Aug 3, 1956</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Ethel M. McHenry</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		JAN 5, 1928		MOBILE, ALABAMA	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15, 1950		MEMPHIS, TENN.		JAMES EARL RAY		JAN 4, 1968		MEMPHIS, TENN.	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
ATTORNEY		JAN 1, 1968		MEMPHIS, TENN.		FEDERAL BUREAU OF INVESTIGATION		JAN 4, 1968		MEMPHIS, TENN.	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		JAN 4, 1968		MEMPHIS, TENN.		DR. JAMES H. HAYES		JAN 4, 1968		MEMPHIS, TENN.	
MANNER OF DEATH		DATE		PLACE		NAME OF CORONER		DATE OF DEATH		PLACE OF DEATH	
NATURAL		JAN 4, 1968		MEMPHIS, TENN.		DR. JAMES H. HAYES		JAN 4, 1968		MEMPHIS, TENN.	
SIGNATURE OF DECEASED		DATE		PLACE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		JAN 4, 1968		MEMPHIS, TENN.		DR. JAMES H. HAYES		JAN 4, 1968		MEMPHIS, TENN.	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF CORONER		DATE OF DEATH		PLACE OF DEATH	
DR. JAMES H. HAYES		JAN 4, 1968		MEMPHIS, TENN.		DR. JAMES H. HAYES		JAN 4, 1968		MEMPHIS, TENN.	
SIGNATURE OF CORONER		DATE		PLACE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
DR. JAMES H. HAYES		JAN 4, 1968		MEMPHIS, TENN.		DR. JAMES H. HAYES		JAN 4, 1968		MEMPHIS, TENN.	

BUREAU V. S.

AUG 5 1956

RECEIVED